Oklahoma State Department of Health
Creating a State of Health

December 12, 2019

License Number: AL6009

Ms. Tonya Wolfe, Administrator
Primrose Retirement Community Of Stillwater
832 S Range Road
Stillwater, OK 74074

Survey Event ID: VFK011

Dear Ms. Wolfe:

Enclosed is a report of the complaint investigation conducted at your Assisted Living facility on **December 4, 2019**. No deficiencies were cited. Oklahoma Statutes require that this report be made available for public inspection within the facility for the next three years.

If you have any questions concerning this report, please call me at (405) 271-6868.

Sincerely,

Lisa Calvin
Long Term Care Enforcement Reviewer
Oklahoma State Department of Health

Gary Cox, JD
Commissioner of Health

Board of Health

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INVESTIGATIVE REPORT
LICENSURE

Facility: **Primrose Retirement Community of Stillwater**
Address: **832 S Range Road**
City, State, Zip: **Stillwater, Oklahoma 74074**
Provider #: **AL6009**
Complaint #: **OK00054657**
Investigation Date(s): **12/04/19**

ALLEGATION(S)	S = SUBSTANTIATED US = UNSUBSTANTIATED
1. The center failed to have adequate staff to provide care to residents per care plans	**US**

☐ **Violation (s) unrelated to this complaint were also cited during the investigation.**

An unannounced on-site investigation was initiated on Wednesday, December 4, 2019 at 8:30 a.m.

A sample of 4 residents including any identified residents, was selected for the investigation based on the concerns relevant to the allegation.

The investigation was conducted following standards set by the statutes, rules and regulations of the State of Oklahoma utilizing Investigative Protocols. Evidence was obtained through observations; interviews with residents, family members, staff members and others as indicated; and review of pertinent written and electronic records.

A Description of Significant Findings Related to Each Allegation is Provided Below:

Allegation #1: The regulation, referenced by the allegation, was unsubstantiated. See the following details related to the investigation.

An investigation specific to adequate staffing and proper use of gait belt.

Four residents were interviewed about sufficient staffing and the extent of assistance each resident required for activities of daily living. All four residents denied any concerns or complaints about a lack of assistance from staff when needed. The resident that was included in the allegation no longer resides at the center, she was discharged on 12/01/19. Three staff members were interviewed, all three replied the staffing was adequate to meet the resident's needs. A staff member was observed transferring a sampled resident from the recliner to the wheelchair utilizing a gait belt. The transfer was completed correctly and safely.

Care plans were reviewed and all care plans addressed resident care appropriately.

Determination Summary and Follow-Up Action:

Deficient practice was unsubstantiated for allegation 1. No further action is required.

A determination that an allegation was unsubstantiated (**US**) is not a judgment, or any reflection of the accuracy of the allegation, nor is it a dismissal of your concern. It means the survey team did not find sufficient evidence at the time of the investigation to confirm a deficient practice or violation of the state regulations had occurred in relation to the allegation.

Thank you for bringing these concerns to our attention.

M Cooper

Mary Cooper RN

Date report completed: 12/04/2019

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL6009	A. BUILDING. _____ B. WING _____	C 12/04/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRIMROSE RETIREMENT COMMUNITY OF STI	832 S RANGE ROAD STILLWATER, OK 74074

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 000	INITIAL COMMENTS An abbreviated survey was completed on 12/04/19 to investigate complaint #OK00054657. Census was 41. No deficient practice was cited.	C 000		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED

SURVEY TEAM COMPOSITION AND WORKLOAD REPORT

Public reporting burden for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing the burden, to Office of Financial Management, HCFA, P O Box 26684, Baltimore, MD 21207, or to the Office of Management and Budget, Paperwork Reduction Project(0838-0583), Washington, D C 20503

Provider/Supplier Number	Provider/Supplier Name
	PRIMROSE RETIREMENT COMMUNITY OF STILLWATER

Type of Survey (select all that apply)

[A] [ ] [ ] [ ] [ ]

A Complaint Investigation
B Dumping Investigation
C Federal Monitoring
D Follow-up Visit
E Initial Certification
F Inspection of Care
G Validation
H Life Safety Code
I Recertification
J Sanctions/Hearing
K State License
L CHOW
M Other

Extent of Survey (select all that apply)

[ ] [ ] [ ] [ ] [ ]

A Routine/Standard Survey (all providers/suppliers)
B Extended Survey (HHA or Long Term Care Facility)
C Partial Extended Survey (HHA)
D Other Survey

SURVEY TEAM AND WORKLOAD DATA

Please enter the workload information for each surveyor Use the surveyor's identification number.

Surveyor ID Number (A)	First Date Arrived (B)	Last Date Departed (C)	Pre-Survey Preparation Hours (D)	On-Site Hours 12am-8am (E)	On-Site Hours 8am-6pm (F)	On-Site Hours 6pm-12am (G)	Travel Hours (H)	Off-Site Report Preparation Hours (I)
1. 41872	12/04/2019	12/04/2019	0.75	0.00	3.75	0.00	4.00	2.00
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3.								
4.								
5.								
6.								
7.								
8.								
9.								
10.								
11.								
12.								
13.								
14.								

Total SA Supervisory Review Hours..... 0.00

Total RO Supervisory Review Hours.... 0.00

Total SA Clerical/Data Entry Hours.... 0.00

Total RO Clerical/Data Entry Hours..... 0.00

Was Statement of Deficiencies given to the provider on-site at completion of the survey?.... **No**

DEC 13 2019